

CLIENT INFORMATION FORM

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Program #					Facility				
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Social Security Number (SSN)									
Birth Date:									
Last Name:									
First name:					Middle Name:				

ADIS ID									
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DETAILS		
General Demographics		
ETHNICITY (Please select one)		
<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican	<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> Other Hispanic	<input type="checkbox"/> Puerto Rican	
TRIBE (Please select one)		
<input type="checkbox"/> Assiniboine	<input type="checkbox"/> Gros Ventre	<input type="checkbox"/> Piegan
<input type="checkbox"/> Blackfeet	<input type="checkbox"/> Kootenai	<input type="checkbox"/> Salish
<input type="checkbox"/> Blood	<input type="checkbox"/> Little Shell	<input type="checkbox"/> Shoshone
<input type="checkbox"/> Chippewa	<input type="checkbox"/> Nez Perce	<input type="checkbox"/> Tribe Unknown
<input type="checkbox"/> Chippewa Cree	<input type="checkbox"/> Northern Cheyenne	<input type="checkbox"/> Turtle Mountain
<input type="checkbox"/> Crow	<input type="checkbox"/> Not Domiciled	<input type="checkbox"/> Yankton Tribal Affiliation
<input type="checkbox"/> Flathead	<input type="checkbox"/> Other Tribe	
RACE (Select all that apply)		
<input type="checkbox"/> White	<input type="checkbox"/> Alaska Native	
<input type="checkbox"/> American Indian (other than Alaska Native)	<input type="checkbox"/> Asian	
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	

Other Demographics		
Level of Education		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status:		
<input type="checkbox"/> Divorced	<input type="checkbox"/> Never Married (including annulled)	
<input type="checkbox"/> Life Partner	<input type="checkbox"/> Separated	
<input type="checkbox"/> Married (including common law)	<input type="checkbox"/> Widowed	

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Name:					Account #:				
Program #					Facility				

CONTACT	
Phone Numbers	
Home:	Ext:
Work:	Ext:
Message:	Ext:
Contact Person:	
Relation:	
Phone:	Ext:

ADDRESS				
<i>(Please select one)</i>	<input type="checkbox"/> Mailing	<input type="checkbox"/> Physical	<input type="checkbox"/> Third Party	<input type="checkbox"/> History
Address:				
City:				
State:				
Zip Code:				
County Name:				
Country:				

ADDRESS				
<i>(Please select one)</i>	<input type="checkbox"/> Mailing	<input type="checkbox"/> Physical	<input type="checkbox"/> Third Party	<input type="checkbox"/> History
Address:				
City:				
State:				
Zip Code:				
County Name:				
Country:				